MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Texas Imaging & Diagnostic Center 3840 W. NW. Highway, Suite 390 Dallas, Texas 75220	MDR Tracking No.: M4-03-6994-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company P O Box 12029 Austin, Texas 78711-2029 Box 54	Date of Injury: Employer's Name: GB & G Construction Incorporated Insurance Carrier's No.: 99B0000297591

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07/23/02	07/23/02	99070-ST	$237.11	$237.11

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position statement.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier states "The requester is disputing this carrier's reimbursement for code 99070-ST. The requester billed $234.11 and this carrier reimbursed the requester $50. Upon review, it appears no additional reimbursement is due and in fact, the request appears to be reimbursed in excess of fair and reasonable reimbursement." EOBs state, "The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.11 (D)."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The provider submitted product information and redacted EOBs from various insurance carriers indicating what they had paid. The information provided indicates that the carriers had reimbursed the full amount the provider billed. The provider had the more convincing evidence that indicates a fair and reasonable rate of reimbursement than the carrier provided per rule 133.307(g)(3)(D). No other denials were noted in the claim file. Therefore, based on the information provided additional reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

						Total Left Column:	$0.00
						Total Amount Due:	$237.11

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled reimbursement in the amount of **$237.11**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

Ordered by:

	Michael Bucklin	02/16/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____